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Patient First: Ethics and Ontology of Nursing Care

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Abstract

In this paper we argue that while attention to and acting upon ethical codes of conduct is paramount in professional nursing conduct, a critical antecedent to ethical behaviour is ontological perception, that is, and how we view the patient as a person. We argue that the nurse's perspective of the essence of patients (e.g., are they a means to our ends or ends in themselves?) - will form the groundwork for the quality of ethical care provided. As a foil for our discussion, we use the 2013 case at the Mid Staffordshire General Hospital in the United Kingdom in which unethical practice among staff place patient health, safety, and dignity at risk. We conclude by offering an ontological dimension to a truly 'patient first' strategy which places the very essence of the patient as primary.

INTRODUCTION

The principle of always putting patients first is, on the face of it, a core value in healthcare. In this article, we discuss reasons why it may not be enacted in practice and what philosophy could contribute to resolving this problem. We begin, by way of illustration, by outlining the case of a UK hospital which became something of a *cause celebre*, leading the government to launch to a full scale public inquiry into failings at the hospital. The findings of the inquiry are in the public domain [1], and have triggered significant changes to healthcare regulation in the UK. We summarise them below, as there important benefits to the public good to be gained from understanding the case.

Between 2005 and 2008, some patients in the Mid Staffordshire General Hospital received what has now been acknowledged to have been a dreadful standard of care. Patients were left in soiled bed clothes for lengthy periods, patients who needed help to eat were not given the assistance they required, water was left out patients' reach, staff treated patients and their families with indifference, and privacy and dignity were denied [2]. In February 2013, Robert Francis QC, chair of the public inquiry in serious failings at Mid Staffordshire NHS Foundation Trust, reported the findings of the inquiry. As he wrote to the Secretary of State for Health: The story it tells is first and foremost of appalling suffering of many patients. This was primarily caused by a serious failure on the part of a provider Trust Board... This failure was in part the consequence of allowing a focus on reaching national access targets, achieving financial balance and seeking foundation trust status to be at the cost of delivering acceptable standards of care [3].

When the scandal came to light, there was widespread expression of concern at the apparent lack of compassion demonstrated by hospital staff. Commentary often focussed particularly on the behaviour of nursing staff, seen as having departed from core values of compassionate care and respect for human dignity. The response of the Nursing and Midwifery Council, the regulatory body for the nursing profession in the UK, included an undertaking to help raise standards and bring about changes in culture needed to make healthcare more patient focussed. The NMC set new standards for nursing education 'to highlight the importance of the values of compassion and care alongside the essential clinical skills needed in the twenty first century' [4]. The NMC also undertook to develop a new Code and standards for practice, due to be published in December 2014 [5]. The response emphasises the importance of ensuring that the Code reiterates the principle of always putting patients first. In the following section of this article, we argue that, whilst a review of educational standards and the Code are positive steps, they do not represent the complete solution to the problem of equipping nurses with the qualities needed to remain focussed on compassionate care and the promotion of human dignity in hard pressed working environments.

ETHICS: PRACTICAL SOLUTIONS

By any standard, the case described above demonstrates a clear violation of ethical care. From a rule- or duty based (or non-consequentialist) perspective the dignity of the patient is paramount [6] and, clearly, patient dignity was not respected. Codes of ethics of the institution as well as the profession provide the rules one must follow that implicitly and explicitly reflect the duty to treat a patient with dignity [7]. Problems arise when codes are not followed due to content and/or intent. When the content of codes is inadequate to provide guidance for problem solving they fall into dis-use as their educational/practical function is

ineffective [8]. Codes then become simple platitudes. Codes can also remain impotent when there is a lack of institutional and/or professional sanction [9]. For example, when codes, however well they are crafted, do not have the backing of the organisation as an educational tool to be promoted or as a human resource guideline that must be followed, they lose effectiveness.

Another ethical perspective that is relevant to this discussion is the consequential school of thought [10]. Here ethical conduct is not measured by duty but rather outcome. "Does my behaviour result in the greatest good?" Clearly there was no good outcome as a result of the behaviour we described in the Mid Staffordshire case. No 'good' outcome was realised by the individual patient, nor was there an eventual good for the hospital itself as a result of what might be deemed as cost cutting measures. Had the hospital and staff taken a broader view of the 'good' outcome (i.e., long-term reputation of the hospital), their behaviour would likely have been quite different.

While there are many more variations of these two very broad schools of thought that can be used to strengthen the ethical resolve of staff, we may be missing a more fundamental root of the problem.

ONTOLOGY: FUNDAMENTAL SOLUTIONS

What underlies ethical behaviour? What motivates how and why we act toward others? Metaphysics or 'first philosophy' may hold the answer to these questions. Specifically ontology, a sub theme of metaphysics, provides us with approaches to understanding the 'essence' of what it is to be a human being [11]. The ontological ethical argument is as follows: my perspective of the value/essence of the other drives my ethical behaviour toward him or her. Two ontological perspectives are worth discussing in a healthcare context means vs. ends and monism vs. dualism. If a nurse perceives the patient as a means to an end, then the patient is objectified and ceases to have relevance as an individual [12]. Worth is based upon the patient being part of the causal chain within the healthcare system. As a nurse, I need patients to care for otherwise I become redundant – patients are needed for me to achieve my goal of being employed and contributing to my family, the organisation, and society. In this scenario my treatment of the patient is irrelevant – as an object, dignity is a non starter. I can function in a calculated efficient manner and achieve my desired end.

On the other hand, if a nurse perceives the patient as an end-in-themselves, the scenario changes dramatically. Seeing others as ends portends that you embrace the unique and subjective nature of each individual. It means that each patient is, by virtue of being human, worthy of dignity. As such, the patient is not an object to be used for other ends but rather of ultimate importance in and of themselves. While this does not preclude efficient and effective care in an institutional setting, it does suggest that the patient's well being is the primary focus.

Dualism vs. monism is another way to discuss ontological positions. This holds particular relevance to the healthcare context as it is the body that is the primary focus. Strict dualism has its roots in Cartesian philosophy in which mind and body are separate entities [12]. Monism in contrast does not acknowledge a separation of mind and body and accepts that we are nothing more than flesh, blood, and complex electro-chemical interactions.

Nursing dualism manifests itself in two ways. As the patient is seen as body and mind, there may be a tendency to identify the patient as the physical host of pathology – mind exists but not the immediate concern of the attending nurse of physician. As a result, physical needs may be addressed but psychological ones, including dignity, may not be. If the patient is physically recovering, the nurse's work is done. Dualism, taken more holistically can also serve the patient more completely. Physical needs can be addressed concurrently with the mental stress and anxiety caused by being a patient (i.e., fear of pain and loss of autonomy).

The outward manifestation of nursing monism is not dissimilar to dualism when mind is acknowledged but is disregarding – a task for psychologists or priest not a cardiac nurse, for example.

IMPLICATIONS

In this paper we argued not against the pragmatic importance of ethics, but rather in favour of an awareness of ontological assumptions in addition to ethical action. Nursing curricula have, generally speaking, well developed approaches to ethical theory and nursing codes of ethics. However knowing a code and putting it into practice are two very different things and one's ontological orientation may have an impact in the degree to which an ethical approach is implicitly accepted and explicitly followed. The means oriented nurse with a penchant to address the body exclusively may have little motivation to act on a code that advocates 'patient first' (i.e., patient as an end-in-themselves).

Conversely, the nurse who sees the patient as an end and who while attending to physical needs can address the incumbent anxiety and stress of 'patient hood' will provide care that is consistent with a patient "first philosophy"

When developing training with the aim of preventing another case like Mid Staffordshire, it may not be sufficient to revise the Code of practice and ensure that students are taught about the values of compassion and care using a technical rational approach. Bilson has argued that the key to teaching ethical practice in social work is encouraging the development of compassionate concern for others, enabling the spontaneous concern for others that is naturally present in human beings to develop and flourish [13]. Experiential approaches, such as the patient 'shadowing' element of Patient and Family Centred Care programmes [14] are one important tool that may help healthcare professionals to understand the patient experience. The King's Fund, a UK health think tank is advocating for the use of PFCC as a practical method for putting patients first in the aftermath of the Mid Staffordshire case [15]. However, in order to be able to consistently enact the values of compassion and care, nurses and other health professionals, also need to reflect upon the meanings that their patients hold for them. They must have the opportunity to uncover the assumptions embedded in their own and colleagues' practice, and to explore alternative ways of understanding what their patients mean to them. Attention to ontological perspectives cannot be done away with. Without this groundwork, knowledge of Codes of ethics and reflection upon

shadowing experiences may be shallow and have limited impact on practice when confronted with the challenges of caring for distressed and needy people in an environment where resources are limited. What practical steps need to be taken?

While ethical conduct can be to a certain extent dictated by professional standards and direct observation/evaluation of behaviour, ontological perspectives are not open to such scrutiny. As a consequence the profession's role can extend only to raising awareness of what ontology is and what to behaviour it may lead. Thus nursing education in general must continue to take the teaching of ethical theory and codes of ethics seriously. We argue that nurse training/education also include the precursor of ethical behaviour ontological perceptions as they pertain to ethical decision-making. This added dimension of the curriculum would enable nurses to be aware of the underlying rationale for their behaviour and provide the philosophical basis to reinforce or to change. The mechanics of how this is disseminated in the classroom is beyond the scope of this paper. However, cursory readings of Martin Buber [16] (I-thou); Martin Heidegger [17] (Calculative vs. Meditative thinking) and even Plato's [18] dialogue Phaedrus may provide some interesting options and points of departure for theory content.

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